CCII

COMPREHENSIVE CARE II, INC.

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WASHINGTON, D.C. 20039
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Ms. Sheila Pannell
Acting Program Manager
Department of Health
Health Regulation & Licensing Administration
825 North Capitol Street, NE., 2nd Fl
Washington, DC 20002

Re: 1329 Longfellow Street, NE

Dear Ms. Pannell,

Herewith are our plans of Corrections to the Statement of Deficiencies found per monitoring survey on December 10, 2007 at 1329 Longfellow St., NE. The facility alleges compliance by January 17, 2008.

For further information, please contact me at the above number.

Sincerely,

Dr. Rodwell Buckley,
Administrator

PRINTED: 12/20/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G153	A. BUILDING _____ B. WING _____	C 12/10/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE II	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A follow-up survey to the September 21, 2007 recertification survey was conducted on December 10, 2007, to verify corrective actions identified in the facility's submitted plan of correction. The findings of this survey were based on observations at the group home, interviews with management and residential staff, and review of records both clinical and administrative to include the review of the facility's unusual incident reports.	W 000	RECEIVED 2007 JAN 14 P 4:02 DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews with direct care staff, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following: The findings include: 1. The governing body failed to ensure that there was an effective system to provide prompt detection, reporting and appropriate follow-up for unusual incidents for Client #4 . [See W153] 2. The governing body failed to ensure that an effective system was in place to ensure the protection of each client's personal property. Observation during an walk-through of the facility on December 10, 2007 at approximately 3:00 PM	W 104	1. Staff received in-service on incident reporting procedure. See atachment 2. Individuals clothing is inventoried See attachment	12-14-07 12-17-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dr. Robert Buck | TITLE: Adm | (X5) DATE: 1/4/08

Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 revealed new clothing in the dresser drawers and closets. The QMRP indicated that new clothing had been purchase as indicated in the September 21, 2007 plan of correction. Interview with the QMRP revealed that agency had not inventoried the client new clothings. The QMRP also revealed that additional clothing will be purchased for the Christmas holiday. Review of the agency's policy did not reflect a system to ensure the protection of the clients' personal property. 3. An unusual incident report, dated September 28, 2007, revealed Client #4 attacked another peer on the van in route to the group home from the day program. The incident report revealed that the driver had to pull over to stop the attack and evaluate the other client for injury. The incident report made no mention of additional staff on the van. The facility failed to have a policy to address client to staff ratio during van transport.	W 104	3. The incident report was completed by van escort. See attachment	9-28-07
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based staff interview and record review, the facility failed to ensure that the day program met the needs of one of the clients residing in the facility (client #1). The finding includes:	W 120		

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W 120	Continued From page 2 The facility failed to ensure that outside services provided active treatment accordance with Client #1's Individual Program Plan (IPP). On December 10, 2007 the QMRP was interviewed to verify the plan of correction (dated September 21, 2007) to address theimplementation of Client #1's behavior support plan at the client's day program. The QMRP revealed that on November 12, 2007 a case conference was held at the day program; however, the client's behavior support plan was not address. There was no evidence that the day program was implementing client #1's behavioral intervention and providing the group home with program data.	W 120	The QMRP and has met with day program BSP is implemented and data will be collected monthly by the 15thof the month for inclusion in medication review.	1-03-07
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, it was demonstrated that facility staff (direct care staff and QMRP) the facility failed to inform each client, parent, or legally authorized party of the attendant risks of treatment regarding the use of psychotropic medication[W124]; the facility failed to address the clients' needs for advocacy to ensure protection of civil and human rights[W125]; the facility failed to ensure and encourage one of the four clients residing in the facility an opportunity to exercise their rights to privacy. [W125; the facility failed to provide evidence of prompt notification of parents or guardians of a significant incident which was	W 122		

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W 122	Continued From page 3 potentially harmful for each client [W148]; failed to ensure that all injuries of unknown origin were reported immediately to the administrator [W153]; and failed to initiate immediate investigation of injuries of unknown origin [W154]; The findings of these systemic practices results in the facility's continued failure to adequately govern the facility in a manner that would ensure that its clients were protected from injuries and potential harm.	W 122	QMRP notified and governing body the day of the incident along with follow up investigation. See Attached	10-3-07
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to inform each client, parent, or legally authorized party of the attendant risks of treatment regarding the use of psychotropic medication for two of three sampled clients. [Clients #1 and #3] The findings include: 1. On December 10, 2007 at approximately 10:00 AM, interview with the QMRP and the review of the plan of correction dated September 21, 2007 indicated that Client #1's consents for the use of psychotropic medication, (1 mg Tab of Xanax XR every morning) would be obtained	W 124	1. Consent have been obtained and the use of psychotropic medication has been approved by HRC	1-3-07

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W 124	Continued From page 4 before the next psychotropic medication review. However, at the time of the follow up visit, the QMRP confirmed that the consents for Client 1#'s medication had not been obtained. Further interview with the QMRP indicated that Department of Disability Services Case manager provided the necessary forms for completing the consent process, however these forms [i.e. Psychologist Affidavit, Medical (Emergency Treatment) Affidavit, and General Medical Affidavit)] had not been finalize. Record review revealed there was no signed nor agreed upon consent on file for this client to receive his current psychotropic medications. 2. On December 10, 2007, interview with the QMRP and the review of the plan of correction dated September 21, 2007, indicated that client #3's consent for the use of 30 mg of Zyprexa (10 mg tab + 20 mg tab) would be obtained before the next psychotropic medication review. At the time of the follow up, the QMRP confirmed that the consent for Client #3's medication had not been obtained. However, at the time of the follow up visit, the QMRP confirmed that the consents for Client 1#'s medication had not been obtained. Further interview with the QMRP indicated that Department of Disability Services Case manager provided the necessary forms for completing the consent process, however these forms [i.e. Psychologist Affidavit, Medical (Emergency Treatment) Affidavit, and General Medical Affidavit)] had not been finalize. Record review revealed there was no signed nor agreed upon consent on file for this client to receive this psychotropic medication.	W 124	2. Consent have been obtained and the use of psychotropic medication has been approved by HRC	1-30-07

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W 124	Continued From page 5 This is a repeat Deficiency.	W 124		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to address the clients' needs for advocacy to ensure protection of civil and human rights. The findings include: 1. On December 10, 2007 at approximately 11:30 AM, interview with the QMRP and verification of the plan of correction date September 21, 2007 indicated that Clients #1 and #3 were unable to make independent decisions. There was no evidence that the facility had address the need for a surrogate decision- maker or guardian to ensure each client's rights. (See W124) 2. Dinner observation on December 10, 2007 at approximately 6:40 PM revealed that the direct care staff assisted Client #2, who was in a wheelchair, to the dining room table. The client was observed with a bed chuck draped around his neck. The chuck was observed to be used as a bib. Interview with the direct care confirmed that the chuck was being used as a bib. Interview with the QMRP revealed as a part of dignity and	W 125	1. Guardianship forms are signed. See Attached 2. Staff have been in-serviced on Rights and Dignity this training will be given quarterly or as needed. See Attached	12-14-07

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W 125	Continued From page 6 rights training, the staff were trained not to use bed chucks as bibs. The QMRP acknowledged that the training was not effective.	W 125		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure and encourage one of the four clients residing in the facility an opportunity to exercise their rights to privacy. (Client #3) The finding includes: The facility failed to ensure direct care staff protect clients' rights to privacy during personal care activities as evidenced below: Direct Care Staff #1 was observed at approximately 5:05 PM to assist Client #2, who was in a wheelchair, into the main level bathroom. Once in the bathroom, the direct care staff immediately put on plastic gloves and assisted the client to the toilet. The bathroom door remain open and the client was observed, from the hallway, during personal care activity. At no time was the direct care staff observed to close the bathroom door.	W 130	Staff has received training on Privacy this training will be done quarterly or as needed. See Attached	12-14-07
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not	W 148		

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W 148	Continued From page 7 limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of prompt notification of parents or guardians of a significant incident which was potentially harmful for each client residing in the facility. The finding includes: Interview with the QMRP and review of the facility's unusual incident reports and investigations on December 10, 2007, at 10:00 AM, failed to show evidence that clients' family and/or guardian was notified immediately of significant incidents. (See W153 and W154)	W 148	QMRP will report incidents per DDS and HRA policy with documented evidence. See Attached	10-3-07 On-going
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensure the health and safety of the three of six clients residing in the facility. 1. Cross-refer to W153. Facility staff failed to implement the agency's policies on incident reporting. They failed to report timely 5 incidents involving in Client #4, which included three injuries of unknown origins.	W 149	1. See Response to W148	

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W 149	Continued From page 8 2. Cross-refer to W154. Facility staff failed to implement the agency's policies on incident investigation. 3. Cross-refer to W159 and W436. The facility failed to establish policy to ensure timely coordination and implementation of consultants' recommendations to address client health and safety needs. 4. Cross-refer to W153. The facility failed to establish policy to ensure sufficient staffing on agency's vans.	W 149	2. Incident will be completed by QMRP/Incident investigator within governing policy time frame. 3. QMRP has had conference with day programs to monitor and address the need of persons served inclusive of trainings and case conferences. 4. Program has policy that does not allow persons to ride in the vehicle with escort.	10-3-07 On-going 1-4-08 On-going
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the governmental agencies as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) The findings include: The review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on October 10, 2007 at 9:45 AM, revealed the facility failed to report the following incident(s) to the	W 153		

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W 153	Continued From page 9 administrator or to the governmental agency. a. An unusual incident report, dated September 28, 2007, revealed Client #4 attacked a peer on the van in route to the group home from the day program. The incident report revealed that the driver had to pull over to stop the attack and evaluate the other client for injury. The incident report made no mention of additional staff on the van. b. An unusual incident report, dated September 23, 2007, revealed that upon a direct care staff's morning arrival to the group home, the staff noticed Client #2's skin to be "pale and damp." The staff was informed by another direct care staff that the client had not eaten breakfast. The direct care staff contacted the nurse and was instructed to take the client to the hospital emergency room. There was no additional information available to determine the cause of the client's condition or what had transpired on the overnight shift. c. An unusual incident report, dated September 29, 2007, revealed that Client #4 attacked a direct care staff while he was assist another client with personal hygiene. With the assistance of another direct care staff, the client had to be restrained and 911 was contacted. The client was transported by the police to the Emergency Response Division for evaluation and treatment. Reportedly, the client bit the staff during the attack and the staff received medical treatment. This incident was not reported to facility's administrator or the government agencies as required state law. d. An unusual incident report, dated September	W 153	A. Van escort was the writer of the incident report B. Staff trained on signs and symptoms of illness See attachment C. Incident Reporting has been in-serviced to staff and Administrator or designee will sign incident reports and assure all governing agencies are notified.	9-28-07 1-4-08 12-14-07

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W 153	Continued From page 10 30, 2007, revealed Client #4's brother contacted the group home and report long scratches on the client's left arm. When the brother asked Client #4 about the scratches, the client commended that another client from "Newton Street" had caused these injuries while on the van. This complaint was not reported to facility's administrator or the government agencies as required state law. e. An unusual incident report, dated October 1, 2007, revealed that Client #4's day program coordinator called the group home to report that scratches discovered on the client's arm. The incident report further disclosed that when asked about the injuries, the client stated that he cut himself with a knife. He further explained that he took a knife from the kitchen while the overnight staff were sleeping. f. Review of an unusual incident report, dated October 3, 2007, revealed that Client #4 informed the direct care staff that during the weekend he took a knife. Staff asked him if they could search his room. The client agreed to the search and led the staff to his bedroom. During the search, the staff discovered disposable razors. Client #4 stated that he used the disposable razors to get the hair off his arms. The knife was not found during the room search. Note: It should be noted that the plan of correction dated October 31, 2007 indicated that staff had been in-service on the agency's incident management policies and procedures, however review of the aforementioned incident reports at the time of this follow up visit failed to evidence that the proper notification were made as outlined in the agency's policy and procedures.	W 153	D. See Response toW153 C. E. See Response to W153 C	

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W 154	This is a repeat deficiency. 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure all unusual incidences of injuries of unknown origin were thoroughly investigated. The findings include: Review of the facility's Unusual Incident log book on December 10, 2007 at 9:45 PM revealed the following incidents and/or injuries of unknown origin were not been investigated: a. An unusual incident report, dated September 28, 2007, revealed Client #4 attacked a peer on the van in route to the group home from the day program. The incident report revealed that the driver had to pull over to stop the attack and evaluate the other client for injury. The incident report made no mention of additional staff on the van. b. An unusual incident report, dated September 23, 2007, revealed that upon a direct care staff's morning arrival to the group home, the staff noticed Client #2's skin to be "pale and damp." The staff was informed by another direct care staff that the client had not eaten breakfast. The direct care staff contacted the nurse and was instructed to take the client to the hospital emergency room. There was no additional	W 154	a. See Response to W104 #3 b. See Response to W153 C	

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	09G153	A. BUILDING _____ B. WING _____	C 12/10/2007

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COMF CARE I I	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011

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W 154	Continued From page 12 information available to determine the cause of the client's condition or what had transpired on the overnight shift. c. An unusual incident report, dated September 29, 2007, revealed that Client #4 attacked a direct care staff while he was assist another client with personal hygiene. With the assistance of another direct care staff, the client had to be restrained and 911 was contacted. . The client was transported by the police to the Emergency Response Division for evaluation and treatment. Reportedly, the client bit the staff during the attack and the staff received medical treatment. This incident was not reported to facility's administrator or the government agencies as required state law. d. An unusual incident report, dated September 30, 2007, revealed Client #4's brother contacted the group home and report long scratches on the client's left arm. When the brother asked Client #4 about the scratches, the client commended that another client from "Newton Street" had caused these injuries while on the van. This complaint was not reported to facility's administrator or the government agencies as required state law. e. Review of an unusual incident report, dated October 3, 2007, revealed that Client #4 informed the direct care staff that during the weekend he took a knife. Staff asked him if they could search his room. The client agreed to the search and led the staff to his bedroom. During the search, the staff discovered disposable razors. Client #4 stated that he used the disposable razors to get the hair off his arms. The knife was not found during the room search.	W 154	c. See Response to W153 C d. See Response to W153 C e. See Response to W153 C	

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W 154	Continued From page 13	W 154		
W 159	This Is a repeat deficiency. 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: 1. The facility's QMRP failed to ensure that the day program met the needs. (See W120) 2. The facility's QMRP failed to address the client's needs for advocacy to ensure their rights were protected. (See W125) 3. Interview with the QMRP and review of the plan of correction dated September 21, 2007 revealed that the facility was to ensure that Client #1's Behavior Support Plan (BSP) be shared with the day program staff. Further interview with the QMRP revealed that it was the responsible of the QMRP to train day program staff on the BSP's interventions and data collection. Although the QMRP revealed that a case conference was held at the day program on November 12, 2007 to address Client #1's medical concerns, there was no evidence that the client's BSP was addressed. Additionally, the QMRP acknowledge that training	W 159	1 .See Response to W120 2. See Response to W125 #1 Training on person # 1 BSP has been completed and will be monitored by QMRP as well as behavior documentation received for implementation in psychotropic medication review and HRC meeting	1-4-08

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W 159	Continued From page 14 had not been completed to ensure that the client's behavioral techniques were being implemented at the day program. 5. The facility Qualified Mental Retardation Professional (QMRP)failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties. [See W189] 6. The Qualified Mental Retardation Professional (QMRP) failed to ensure the review and approval of psychotropic medication for clients. [See W124 and W262] 7. The Qualified Mental Retardation Professional (QMRP) failed to ensure the accurate assessment and management of presenting problems of each client. [See W224 and W225] 8. The Qualified Mental Retardation Professional (QMRP) failed to ensure the implementation and documentation of client ' s active treatment programming. [See W249 and W252] 9. The Qualified Mental Retardation Professional (QMRP) failed to ensure that direct care staff were trained effectively on Infection control. (See W454 and W455)	W 159	5. Staff have received training on person rights, privacy, signs and symptoms of illness, incident reporting, documentation, nutrition, behavior support plans, and infection control 6. See Response to W124 7. Assessments completed for all persons 8. See Response to W159 # 3 & #7 9. staff retrained on infection control	By 1-4-08 12-18-07 12-18-07
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 189		

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W 189	Continued From page 15 failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. The findings include: 1. The facility failed to ensure that food is prepared in a form consistent with Client #2's prescribed dietary needs as evidenced below: During observations on December 10, 2007 at approximately 6:32 PM, Client #2's was served a plate of food consisting of one chicken leg, white rice and broccoli spears. The client began to eat his food using a regular table spoon. The client was observed attempting to cut the chicken from the bone using his spoon. After several unsuccessful attempts, the client used his hands to pull large pieces from the bone. After which the client placed the pieces in his mouth. Due to his strong tongue thrust and his poor upper body positioning, the meat fell out of his mouth and on to his plate. After the client finished his meal, a great amount spillage was observed. There was no attempt by the direct care staff to assist the client in cutting his meat in a manageable texture. Interview with the QMRP revealed that the direct care staff had been trained by the nutritionist on October 21, 2007 on each client's diet order, preferred food texture and the appropriate eating equipment to be used during meals. Additionally the nutritionist trained staff on food substitutions, menus, food thickener and portion control. Review of the nutritionist training material revealed that the nutritionist noted that Client #2's was prescribed a regular chopped textured diet.	W 189	1. Staff trained on each person meal protocol	

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W 189	Continued From page 16 2. Direct Care Staff #1 was observed at approximately 5:05 PM to assist Client #2, who was in a wheelchair, into the main level bathroom. Once in the bathroom, the direct care staff immediately put on plastic gloves and assisted the client to the toilet. The bathroom door remained open and the client was observed, from the hallway, during personal care activity. At no time was the direct care staff observed to close the bathroom door. 3. Dinner observation on December 10, 2007 at approximately 6:40 PM revealed that the direct care staff assisted Client #2, who was in a wheelchair, to the dining room table. The client was observed with a bed chuck draped around his neck. The chuck was observed to be used as a bib. Interview with the direct care staff confirmed that the chuck was being used as a bib. Interview with the QMRP revealed as a part of dignity and rights training, the staff were trained not to use bed chucks as bibs. The QMRP acknowledged that the training was not effective. 4. The facility failed to ensure that the Physical Therapist provided training on the adaptive support for Client #2. (See W436) 5. The facility failed to ensure that direct care staff were effectively trained on infection control practice. (See W454)	W 189	2. See Response W159 #5 3. See Response W159 #5 4. Training completed by PT on use of adaptive equipment 5. See Response W159 #5	1-8-08
W 224	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community.	W 224		

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W 224	Continued From page 17 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure clients were assessed to determine their ability and needs with regards to budgeting for three of three sampled clients. (Client #2, #4 and #5) The finding includes: On December 10, 2007 a follow up visit was completed to verify plan of correction dated October 31, 2007. At the time of this visit evidenced the following: On December 10, 2007 at approximately 1:40 PM, interview with the QMRP and review of the Client ' s #2, #4 and #5 habilitation records did not evidence that the QMRP had facilitated money management assessment to determine their financial management skills. Record review revealed there was neither a money management assessment nor a money management program on file for the Client's to enable them to manage their finances to the best of his ability. This is a repeat deficiency.	W 224	See Response to W159 #7	
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to ensure that clients were provided	W 225		

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W 225	Continued From page 18 the provisions of a vocational skills assessment. The finding includes: On December 10, 2007 a follow up visit was completed to verify plan of correction dated October 31, 2007 which indicated that Client #2 had been assessed in the area of vocational development. Interview with the QMRP and review of the habilitation records on December 10, 2007 at approximately 2:15 PM revealed no evidence of a vocational assessment for Client #2. According to the QMRP, the assessment will be scheduled, but did not provide a specific date or time. This is a repeat deficiency.	W 225	See Response to W159 # 7	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that clients receive interventions as specified in their Individual Program Plans for two of three sampled clients. [Clients #1 and #3] The findings include:	W 249		

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W 249	Continued From page 19 On December 10, 2007 a follow up visit was completed to verify plan of correction dated October 31, 2007. At the time of this visit there was no evidence that the following deficiencies cite on September 20, 2007 had been corrected: 1. Interview with the QMRP on December 10, 2007 revealed that Client #3 had not been involved in a reading and numbers recognition program objective to enhance his skills as defined in the plan of correction. According to the QMRP the establishment of this objective was still being considered. 2. Interview with the QMRP on December 10, 2007 revealed that a case conference was held at the day program in November 2007. The QMRP acknowledged that the client's behavioral support plan was not addressed at the case conference. Additionally, the day program staff were not trained on how to implement the behavioral interventions; and therefore, the behavior program was not being implement at the day program.. This is a repeat deficiency.	W 249	1. Program developed to address reading and counting 2 .See Response to W159 #3	12-18-07
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by:	W 252		

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W 252	Continued From page 20 Based on observation, staff interview and record review the facility failed to ensure the implementation of an effective system of documenting a client ' s progress on his programming objectives for two of three sampled Clients. [Clients #1 and #3] The finding includes: On December 10, 2007 a follow up visit was completed to verify plan of correction dated October 31, 2007. At the time of this visit there was no evidence that the following deficiencies cite on September 20, 2007 had been corrected since the initial survey: 1. At the follow up visit on December 10, 2007, interview with the QMRP revealed that direct care staff were trained in the implementation of Client #3 money management program. The QMRP also revealed that a system for documenting the money management program had been established. Review of the data collection, however, revealed that data had not been consistently documented for the past three months (September, October and November). 2. On December 10, 2007 the QMRP was interviewed to verify the plan of correction (dated September 21, 2007) to address the facility's system for documenting Client #1's behavior support plan data collection at the client's day program. The QMRP revealed that on November 12, 2007 a case conference was held at the day program; however, the client's behavior support plan was not address. There was no evidence that the day program was collecting data in the form and frequency required by the	W 252	1. Program is implemented and monitored by QMRP 2. See Response to W159 #3	12-18-07

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W 252	Continued From page 21 client's behavior support plan.	W 252		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure the Human Right Committee ' s oversight and approval for the use of psychotropic medication for two of three sampled clients. [Client #1 and #3] The findings include: 1. On December 10, 2007 at 10:50 AM, interview with the QMRP and the review of the plan of correction dated September 21, 2007, the facility indicated that Client #1 is prescribed psychotropic medication, 1 mg Tab of Xanax XR every morning, this medication was too have been reviewed and approved by the Human Rights Committee for the Clients's usage. Further interview with the facility ' s Registered Nurse (RN) and Qualified Mental Retardation Professional (QMRP) on at 11:00 AM revealed the Xanax XR is prescribed to manage Client #1's maladaptive behaviors. At the time of the follow up visit on December 10, 2007, the QMRP confirmed that the consents for Client #1's medication had not been obtained. Review of the medical records revealed no evidence that the client's medications had been	W 262	See Response W124 #1	12-18-07

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W 262	Continued From page 22 approved by the Human Rights Committee. 2. On December 10, 2007 at 11:15 AM, interview with the QMRP and the review of the plan of correction dated September 21, 2007, the facility indicated that Client #3 is prescribed 30 mg of Zyprexa (10 mg tab + 20 mg tab) was too have been reviewed and approved by the Human Rights Committee for the Client's usage. Further interview with the facility's Registered Nurse (RN) and Qualified Mental Retardation Professional (QMRP) on at 11:00 AM revealed Zyprexa is prescribed to manage Client #3 ' s maladaptive behaviors. At the time of the follow up visit on December 10, 2007, the QMRP confirmed that the consents for Client #3's medication had not been obtained. Review of the medical records revealed no evidence that the client's medications had been approved by the Human Rights Committee. This is a repeat deficiency.	W 262	2. See Response to W125 #1	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to provide preventive and general medical care. The finding includes: The facility failed to ensure current physician's orders were available for review. (See W331)	W 322	Current Physician are in the facility and will be checked monthly by the first day of the month.	12-11-07

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W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's attending nurse failed to ensure the coordination of services two of the client's residing in the facility. [Client #1 and #2]. The findings include: 1. The facility nurse staff failed to ensure that the Physical Therapist recommendations were implemented in regards to Client #2's posture and spine concerns identified in the in the PT assessment. (See W436) 2. The facility nursing staff failed to ensure effective training in infection control. (See W189) 3. The facility nursing staff failed to ensure that current physician orders were available in the group home and in the day program for Client #1 and #2. On December 10, 2007, at approximately 10:30 AM, interview with the nursing staff and review of the medical records revealed that current physician's orders were not on file for Clients #1 and #2. According to the nurse, the orders were sent to the primary care physician for his signature and were to be picked up by the direct care staff. Reportedly, there had been dietary and medication changes that were not reflected on the previous orders (November 2007).	W 331	PT in the home for assessment of adaptive equipment 2. See Response W159 # 9 3. See Response W322	12-14-07
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436		

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W 436	Continued From page 24 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that maintenance and up-keep of a client's adaptive equipment for one of five clients residing in the facility. [Client #2 and #3] The findings include: 1. A follow up visit was completed on December 10, 2007 to verify plan of correction dated October 31, 2007. At the time of this visit Client #3 was not observed wearing his prescribed eye glasses. Interview with the nurse and the QMRP revealed that the client's eye glasses had not been replaced. Also, there was no evidence that the client had been trained in caring for his glasses. 2. During dinner observation on December 10, 2007 at approximately 6:40 PM Client #2 was observed bent forward over his plate at the dining room table. At no time was the staff observed to encourage Client #2 to sit up in his wheelchair to provide the support needed to eat his dinner. Interview with the nurse revealed that the Physical Therapist (PT) had recommended a	W 436	Person # 3 misplaced his glasses appointment has been scheduled for replacement. 2. See Response to W331	

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	09G153	A. BUILDING _____ B. WING _____	C 12/10/2007

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W 436	Continued From page 25 trunk support strap. Further interview revealed that the nurse had purchased the support strap for the client use, however, the PT had not returned to the facility to inspect the chest strap to ensure appropriateness for Client #2 to use. The Nurse further revealed that the PT will need to train the direct care staff in the proper use of the support. Review of the habilitation records failed to evidence that the chest support had been presented to the Human Right Committee for approval. Additionally, the nurse indicated that a plate riser was recommended for Client #2 to use during meals also to help with his posture and to make his food closer to him at the dinner table. The PT had not ensure that this recommendation was implemented for Client #2. Review of the Physical Therapist assessment dated 9/03/07 revealed the following recommendations: 1. Do a trail with a chest strap to assist with upright sitting; 2. Consider brake handle extension; 3. Use the 24/7 one on one for safety; 4. Consider using a phone book under [The Client's] plate to determine if this will promote a more upright sitting posture when eating. A Dycem mat under his plate is appropriate;. 5. Consider an x-ray of the spine to rule out scoliosis and establish a baseline of his current alignment. An Orthopedist can use the Cobb method to quantify his spinal alignment. This information can be used to fabricate [The Client] a trunk brace to promote trunk extension if needed to prevent further deformity; and 6. Consider positioning [The Client] in the prone	W 436		

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W 436	Continued From page 26 position 2 times a day for 15 minutes to increase his cervical, trunk and hip extention range of motion and strength. Reportedly, the only recommendation implemented and completed was the purchase of the chest strap for Client #2. None of the other supports for the client had have been baseline and/or implemented at the time of the follow up visit.	W 436		
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection. The finding includes: On December 10, 2007 at approximately 3:50 PM the Client #5, who was arriving from her day program, was observe with a large wet spot in the seat of her pants. Client #5 went immediately into the bathroom on the main level. The client was observed to leave the bathroom with the same wet pants. He walked into the living room and sat on the couch. Moments later, the direct care staff noticed that Client #5 pants were wet and took the client upstairs to his bedroom. Client #5 returned from his bedroom wearing dry pants. The staff returned downstairs wearing latex gloves and carrying the client's wet pants and wet underwear. The staff was observed to dropped the wet clothing on the carpet in the foyer. Wearing the same latex gloves, the staff entered	W 454	See Response to W159 #9	

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W 454	Continued From page 27 the main level bathroom, touching the door knob and sink area. The staff then return to the foyer and pick up the wet clothing from carpet and went downstairs to the basement. At no time during this observation was the plastic gloves discarded. Additionally the direct care staff person was not observed to return to clean/sanitize the soiled couch, sink, door knob, or carpet in the foyer.	W 454		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve foods in a form consistent with dietary orders for one of the six clients residing in the facility. (Clients #1) The finding includes: The facility failed to ensure that food is prepared in a form consistent with Client #2's prescribed dietary needs as evidenced below: During observations on December 10, 2007 at approximately 6:32 PM, Client #2's was served a plate of food consisting of one chicken leg, white rice and broccoli spears. The client began to eat his food using a regular table spoon. The client was observed attempting to cut the chicken from the bone using his spoon. After several unsuccessful attempts, the client used his hands to pull large pieces from the bone. After which the client placed the pieces in his mouth. Due to his strong tongue thrust and his poor upper body positioning, the meat fell out of his mouth and on	W 474	See Response to W189 # 1	

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W 474	Continued From page 28 to his plate. After the client finished his meal, a great amount spillage was observed. There was no attempt by the direct care staff to assist the client in cutting his meat in a manageable texture. Interview with the QMRP revealed that the direct care staff had been trained by the nutritionist on October 21, 2007 on each client's diet order, preferred food texture and the appropriate eating equipment to be used during meals. Additionally the nutritionist trained staff on food substitutions, menus, food thickener and portion control.	W 474		

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I 000	INITIAL COMMENTS A follow-up licensure survey to the September 21, 2007 licensure survey was conducted on December 10, 2007, to verify corrective actions identified in the facility's submitted plan of correction. The finds of this survey were based on observations at the group home, interviews with management and residential staff, and review of records both clinical and administrative to include the review of the facility's unusual incident reports.	I 000		
I 041	3502.2(a) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (a) Prescribed in the resident ' s Individual Habilitation Plan and the record of the prescription for the modified diet shall be kept in the resident ' s record; This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one on the residents in the sample receive her prescribed modified diet. (Resident #1) The finding includes: See Federal Deficiency Report W474	I 041	**See Response W189 # 1**	
I 052	3502.10 MEAL SERVICE / DINING AREAS Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident.	I 052		

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I 052	Continued From page 1 This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP failed to ensure the availability of recommended adaptive supports. The finding includes: See Federal Deficiency Report - Citation W120, W436	I 052	**See Response W189 #4**	
I 375	3519.6 EMERGENCIES Each GHMRP shall document each emergency and enter the follow-up actions into the resident's permanent record, which shall be made available for review by authorized individuals. This Statute is not met as evidenced by: Based on observations, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to document each emergency action and enter the follow up action in each residents record and make this information available for authorized individuals. (Resident #4 and #2) The findings include: See Federal Deficiency Report Citation - Citation W153 and W154	I 375	**See Response W153 – C**	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially	I 379		

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I 379	Continued From page 2 interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on observations, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to report to its administrator and to governmental officials the mistreatment, thoroughly investigated and notification made to guardians. (Resident #4 and #2) The findings include: See Federal Deficiency Report Citation Citation W148, W153 and W154	I 379	**See Response W153 –C**	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to ensure professional vocational services were provided for one of the residents residing in the facility. The finding includes:	I 401	**See Response W159 # 7**	

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I 401	Continued From page 3 See Federal Deficiency Report - Citation W322 , W331	I 401		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum levels of physical, mental and social functioning. The finding includes: See Federal Deficiency Report Citations W224, W225, W249 and W252	I 420	**See Response W159 #7**	
I 423	3521.4 HABILITATION AND TRAINING Each GHMRP shall monitor and review each resident ' s Individual Habilitation Plan on an ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP. This Statute is not met as evidenced by:	I 423		

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I 423	Continued From page 4 Based on interview and record review, the GHMRP failed to ensure each resident's Individual Habilitation Plan had been monitored to make certain each resident participated and the plans were revised as needed. The findings include: See Federal Deficiency Report Citation - W120, W159, W249, and W252	I 423	**See Response W120, W159 #3**	